Report

of the

Examination of

Gundersen Lutheran Health Plan, Inc.

La Crosse, Wisconsin

As of December 31, 2003

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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August 5, 2004

Honorable Jorge Gomez
Commissioner of Insurance
Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

GUNDERSEN LUTHERAN HEALTH PLAN, INC.
La Crosse, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Gundersen Lutheran Health Plan, Inc. (Gundersen or the HMO) was conducted in 2001 as of December 31, 2000. The current examination covered the intervening period ending December 31, 2003, and included a review of such 2004 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the company's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the Company
Reinsurance
Financial Statements
Accounts and Records
Data Processing

Emphasis was placed on the audit of those areas of the company's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the company to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results" contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the company's operations is contained in the examination work papers.

The company is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

Gundersen Lutheran Health Plan, Inc., is described as a nonprofit network model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as ". . . a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the network model, the company provides care through contracts with two or more clinics. HMOs compete with traditional fee-for-service health care delivery.

Gundersen was incorporated on March 31, 1995, as a nonstock service insurance corporation under ch. 613, Wis. Stat., and commenced business September 1, 1995. The HMO is controlled by Gundersen Clinic, Ltd. (the Clinic) and Gundersen Lutheran Medical Center, Inc. (the Medical Center) the HMO's primary clinic and founder. Prior to the formation of the HMO, the Clinic administered a managed-care product called Security Care, in conjunction with Security Health Plan of Wisconsin, Inc. (SHP), Marshfield, Wisconsin. On August 30, 1995, the HMO entered into an agreement whereby SHP transferred the business previously administered by the Clinic to the HMO. Under the terms of the agreement, Gundersen assumed SHP's rights and obligations under the SHP insurance contracts and plan agreements.

The HMO has 230 participating primary care physicians and 312 participating specialist physicians. Members may seek services from any of the primary or specialty care providers within the HMO participating provider network; however, are encouraged through new member materials to select a primary care provider to coordinate their medical care.

The HMO uses one standard agreement for all providers. Primary care physicians are HMO-participating providers practicing medicine in the fields of family practice, general internal medicine, pediatrics, or obstetrics/gynecology. Providers are contracted to provide those professional medical services, supplies and procedures that the provider customarily provides, in accordance with the HMO's policies and guidelines. The majority of providers are compensated on a discounted fee-for-service basis; however, the Clinic and Medical Center (jointly known as

Gundersen Lutheran) are currently reimbursed a percentage of premiums, which will be discussed later in the report. The contracts include hold-harmless provisions for the protection of policyholders. The hold-harmless provision requires providers to continue services in the event of the company's insolvency through the period for which the premium has been paid, and benefits to Members confined in an inpatient facility on the date of insolvency until their discharge. The contracts have a one-year term, with automatic renewal, and may be terminated by either party upon 90 days' prior written notice thereof prior to the end of a term.

The HMO's major provider contract is with Gundersen Lutheran. Under this provider agreement, Gundersen Clinic Ltd., including its 20 satellite clinics located in Wisconsin, Iowa, and Minnesota, and Gundersen Lutheran Medical Center, Inc., agree to provide participating provider, primary care provider, and specialist, participating hospital, and referral hospital health services covered by the HMO on a capitated basis. The HMO calculates the capitation paid to Gundersen Lutheran by using premium earned as a starting point and deducting administrative costs, broker fees, reinsurance premium, etc., from that amount. Administrative costs are charged as a percentage of premiums while all other deductions are based on actual charges. The agreement is effective January 1, 1996, and has an automatic renewal provision. Either party may terminate the agreement by providing written notice 90 days prior to the end of the term.

The HMO also has agreements with ChiroCare of Wisconsin and Express Scripts, Inc., for chiropractic and prescription management services, respectively. Under these agreements the HMO pays the IPA/administrator a per-member per-month fee to cover administrative services in addition to the agreed-upon fees for the various claims.

The HMO contracts with 15 hospitals to provide inpatient services. Hospitals are reimbursed on a discounted fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders. The following is a list of hospitals with which the HMO Contracts:

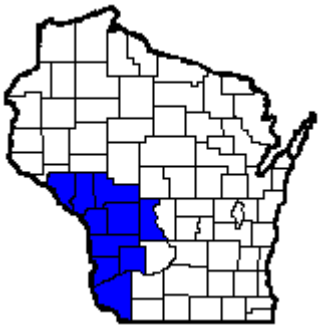
Wisconsin
Black River Memorial Hospital
Boscobel Area Health Care
Gundersen Lutheran Medical Center, Inc.
Hess Memorial Hospital
Prairie du Chien Memorial Hospital
Richland Hospital
St. Joseph's Community Health Services
Tomah Memorial Hospital
Tri-County Memorial Hospital
Vernon Memorial Hospital

Minnesota
Winona Community Memorial Hospital

Iowa
Guttenberg Municipal Hospital
Palmer Lutheran Health Center
Veterans Memorial Hospital – Waukon
Winneshiek County Memorial Hospital

According to its business plan, the company's service area is comprised of the following counties:

Buffalo
Crawford
Grant
Jackson
Juneau
La Crosse
Monroe
Richland
Trempealeau
Vernon



The HMO offers comprehensive health care coverage which may be changed by riders to include deductibles and copayments. Because the HMO offers various benefit designs, health care coverage varies depending which benefit package the group chooses. The following basic health care coverages are provided:

Hospital Services
- Unlimited number of days of care
- Inpatient rehabilitation – includes physical, speech and occupational therapy

Physician services
- Office visits, urgent care, chiropractic – copay $10
- Inpatient visits
- Medically necessary physical exams – copay $10 – One annual routine exam paid-in-full
- Medically necessary surgery/anesthesia

- Vision care exams – copay $10 – One annual vision exam paid-in-full
- Immunization and injections
- Outpatient rehabilitation – includes physical, speech and occupational therapy – 50 visit combined annual maximum
- Temporomandibula joint dysfunction – lifetime max of $500

X-Ray and Laboratory

- Included in-office visits. No copay if only service performed.

Dental Services

- Dental accidents to natural teeth
- Oral surgery

Transplant Coverage

- Heart, liver, cornea and bone marrow based on diagnosis

Maternity Services

- Physical services
- Hospital services
- Maternity coverage for all female participants

Emergency Services

- Emergency Room
- Ambulance

Prescription Drugs

- Brand - $15 copay
- Generic - $10 copay
- Brand if no generic available - $10 copay

Durable medical Equipment – paid at 80%

Hospice – 180-day minimum

Mental Health and Alcohol/Chemical Dependency – annual benefit

- Inpatient care – 30 days
- Transitional care – 30 days
- Outpatient care – 30 days

Dependent Coverage

- Dependent children, grandchildren
- Totally disabled dependent

Mandated benefits

- Diabetic services
- Skilled nursing care
- Home health care
- Kidney disease treatment
- Chiropractic care - $10 copay
- Screening mammograms
- Nurse Practitioner services
- Drugs for treatment of HIV infection
- Blood tests for lead poisoning

Inpatient mental health and AODA coverage is limited to 30 days, outpatient mental health and AODA coverage is limited to 30 days per year, emergency services have a $50.00 copayment which is waived upon admission into an inpatient facility, and skilled nursing care is limited to 30 days per confinement. Members are required to use the services of participating providers except in cases of emergency care or through prior written referrals from the medical director.

In addition to traditional HMO products, the HMO has third-party administration (TPA) contracts with an affiliated entity, Gundersen Lutheran Administrative Services, Inc. (GLAS). The HMO agrees to provide underwriting and claim services, and provide all other general administrative personnel and facilities necessary for the proper administration of the plan. As consideration for the responsibilities being assumed, GLAS agrees to pay the HMO $30.70 per employee per month, for medical, prescription drug, and ChiroCare administration. An additional $4.00 per employee per month is paid for dental administration. GLAS is also responsible for reimbursing the HMO for claims paid on a monthly basis. The agreements are effective January 1, 2003, and have automatic renewal provisions. Either party may terminate the agreement by providing written notice 90 days prior to the end of the term. The HMO also acts as a TPA under a "Letter of Intent" with one non-affiliated corporation. The two parties are currently working on a contract that will be mutually agreeable. In addition, the HMO provides claims payment and processing services for one government client.

In 1999, the HMO entered into an agreement with the then federal Health Care Financing Administration to market a Medicare+Choice product, Gundersen Lutheran Senior Preferred. This is a comprehensive medical plan that combines coverage with those services provided by traditional Medicare with the wellness and preventive care benefits offered by the HMO. Senior Preferred is currently offered in five counties in Western Wisconsin, and is available only through marketing representatives who are employed directly by the plan.

The HMO also writes a point-of-service (POS) product, which prior to January 1, 2002, was marketed with Allianz Life Insurance Company of North America (Allianz) under a joint group contract issued by the HMO and Allianz together with several liability products. As of January 1, 2002, Gundersen assumed the liability of Allianz under these point-of-service policies by entering into an assumption reinsurance agreement. Under a point-of-service plan, members are allowed to choose service with a participating or non-participating provider, with different benefit levels associated with the use of participating providers.

With the exception of the Medicare+Choice product, the HMO markets to groups only. This marketing is done through outside agencies, as well as through the HMO's marketing

manager. The marketing manager does not receive any commissions for sales; however, outside agents are compensated as follows:

New business – 8.27% for the first $15,000 of premium, declining to .50% for premium over $2,000,000

Renewal business – 6.2% for the first $15,000 of premium, declining to .40% for premium over $2,000,000.

The company uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, and coverage characteristics for new groups. Experience is reviewed for renewal groups and, based on the review, a recommendation is made regarding adjusting the rate or cancelling the group.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of fifteen members. One-third of the directors are elected annually to serve a three-year term. Officers are appointed by the board of directors. Members of the HMO's board of directors may be members of other boards of directors in the holding company. The board members do not receive compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Gary Bryant, MD Stoddard, WI	Physician – Gundersen Lutheran	2005
Michael Donlan, MD La Crosse, WI	Physician – Gundersen Lutheran	2005
Jim Fullerton La Crosse, WI	Retired	2004
Mary Lu Gerke La Crosse, WI	Vice President of Region - Gundersen Lutheran	2006
Susan Halter, MD La Crosse, WI	Physician – Gundersen Lutheran	2005
Mark Heberlein, MD Viroqua, WI	Physician – Gundersen Lutheran	2004
Herb Heili Onalaska, WI	Executive Vice President	2006
Shanu Kothari, MD La Crosse, WI	Physician – Gundersen Lutheran	2006
Mary Lund La Crosse, WI	Vice President of Human Resources	2005
Brent Smith La Crosse, WI	Attorney	2004
Dick Swantz La Crosse, WI	University of Wisconsin Professor	2005
Jeff Thompson, MD La Crosse, WI	Physician – Gundersen Lutheran	2006
Jeff Treasure La Crosse, WI	Chief Financial Officer - Gundersen Lutheran	2005
Linda Zoerb La Crosse, WI	Chief Executive Officer - La Crosse Floral	2006
Pat Killeen La Crosse, WI	Executive Director - Gundersen Lutheran Health Plan	2005

Officers of the Company

The officers appointed by the board of directors and serving at the time of this examination are as follows:

Name	Office	2003 Salary
Gary Bryant, MD	President	*
Herb Heili	Vice President	*
Michael Dolan, MD	Secretary	*
Jeff Treasure	Treasurer	*

* Officers are compensated by Gundersen Lutheran Administrative Services, Inc. A recommendation was made regarding the reporting of the HMO's executive compensation; which is discussed further in the report in the section captioned "Summary of Examination Results."

Committees of the Board

The company's bylaws allow for the formation of certain committees by the board of directors. The management committees at the time of the examination are listed below:

Compliance Operations Committee
Kari Adank, Chair
Joan Benson
Cindee Bottcher
Ruth Breidel
Brian Eck
Melissa Holthaus
Ann Kiel
Angie Kissinger
Heather Liethen
Jenny Noren
Tammy Ree
Jeanie Robinson
Tina Shuda
Jayne Spindler
Cheryl Thienes
Sam Schmirler

Compliance Oversight Committee
Patrick Killeen, Chair
Kari Adank
James Fullerton
Thomas Taylor
Jeff Treasure
Brian Proctor

Grievance and Appeals Committee
Patrick Killeen, Chair
Joan Benson
Gary Bryant, MD
Bernard Hammes, PhD
Ann Kiel
Laura Krister, MD
Jenny Noren
Tina Shuda
Ken Kittleson
Heather Liethen
Michael Madar, MD
Marc Williams, MD

Management Committee
Patrick Killeen, Chair
Kari Adank
Joan Benson
Cindee Bottcher
Gary Bryant, MD
Brian Eck
Tim Ferrier
Melissa Holthaus
Ann Kiel
Angie Kissinger
Sam Schmirler
Jayne Spindler, RN, BSN
Cheryl Thienes

Medical Director's Committee
Gary Bryant, MD, Chair
Kathy Callan, RHIA
William Davis, MD
Ann Kiel
Patrick Killeen
Angie Kissinger
Gary Lenth, MD
Laura Krister, MD
Edwin Overholt, MD
Jayne Spindler, RN, BSN
Cheryl Thienes
John Udell, MD
Marc Williams, MD

Operations Leadership Committee
Angie Kissinger, Chair
Cindee Bottcher
Joan Benson
Brian Eck
Ann Kiel
Jayne Spindler, RN, BSN
Cheryl Thienes
Roxane Schleich
Melissa Holthaus

The HMO has four subcommittees that report directly to the Medical Director's Committee. These committees at the time of the examination are as follows:

Credentialing Subcommittee
Pharmacy and Therapeutics Subcommittee
Quality Improvement Subcommittee
Utilization Management Subcommittee

The HMO has no employees. Necessary staff is provided through a management agreement with Gundersen Lutheran Administrative Services, Inc. (GLAS) Under the agreement, effective January 1, 2003, GLAS agrees to provide enrollment, billing and premium collections, claims processing and evaluation, regulatory relations, development of premium rates, investment and asset management, provider relations, agent contracting, operational policies and procedures, plan administration, program planning and development, financial and accounting systems and services, coordination of benefits, data processing and information services, health insurance marketing and sales, peer and utilization reviews, human resources, and legal services. GLAS receives reimbursement on a monthly basis at the actual cost of services and materials provided. The term of the agreement is one year with automatic renewal on an annual basis. The company may terminate the agreement upon 60 days' written notice prior to the renewal.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

		Amount Required
1.	Minimum capital or permanent surplus	Either: $750,000, if organized on or after July 1, 1989 or $200,000, if organized prior to July 1, 1989
2.	Compulsory surplus	The greater of $750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3.	Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million or 110% of compulsory surplus
4.	Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;

2. One-third of 1% of premium written in this state in the preceding calendar year.

The company has satisfied this requirement for 2003 with a deposit of $1,100,000 with the State Treasurer.

Insolvency Protection for Policyholders

Under s. Ins 9.04 (6), Wis. Adm. Code, HMOs are required to either maintain compulsory surplus at the level required by s. Ins 51.80, Wis. Adm. Code, or provide for the following in the event of the company's insolvency:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

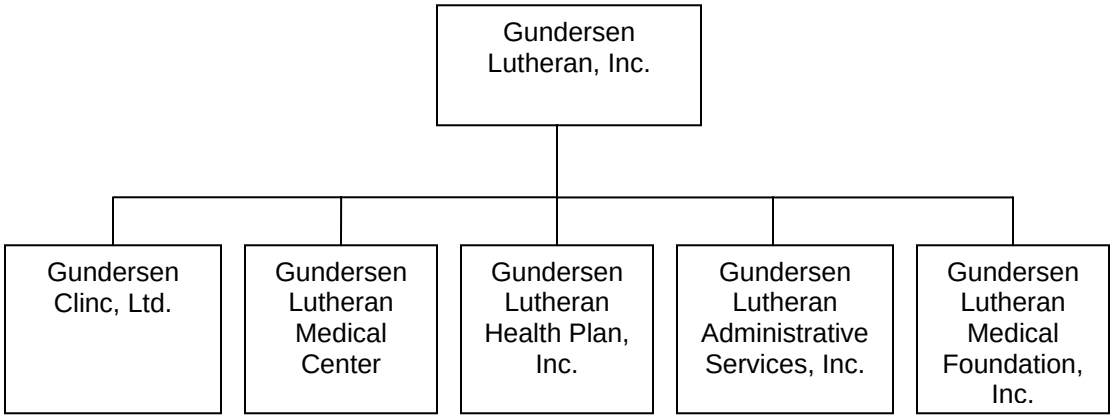
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The company has met this requirement through provisions in its provider contracts and through its reinsurance contract, as discussed in the “Reinsurance and Corporate Insurance” section of this report.

IV. AFFILIATED COMPANIES

The HMO is a member of a holding company system. Its ultimate parent is Gundersen Lutheran, Inc. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the HMO follows the organizational chart.

Holding Company Chart
As of December 31, 2003



Gundersen Lutheran, Inc.

Gundersen Lutheran, Inc., is the sole parent member of Gundersen Clinic, Ltd., Gundersen Lutheran Medical Center, Inc., Gundersen Lutheran Administrative Services, Inc. (GLAS), Gundersen Lutheran Medical Foundation, Inc. (Foundation), and Gundersen Lutheran Health Plan. There are no individual audits done for the Clinic, Medical Center, GLAS or the Foundation. Instead a combined audited financial statement is prepared for the obligated group of corporations. As of December 31, 2003, the combined audited financial statement reported assets of $577 million, liabilities of $260 million, and equity of $317 million. Operations for 2003 produced net income of $52.2 million.

Gundersen Clinic, Ltd.

Gundersen Clinic, Ltd., a nonprofit, Wisconsin corporation, provides comprehensive medical care to patients and conducts medical education and research programs in Wisconsin,

Iowa, and Minnesota. As of December 31, 2003, the Clinic's unaudited financial statement reported assets of $191 million, liabilities of $112 million, and net assets of $79 million. Operations for 2003 produced net income of $6.1 million.

Gundersen Lutheran Medical Center

Gundersen Lutheran Medical Center, a nonprofit, Wisconsin corporation, provides medical care in La Crosse, Wisconsin. As of December 31, 2003, the Medical Center's unaudited financial statement reported assets of $205 million, liabilities of $5 million and net assets of $199 million. Operations for 2003 produced net income of $40.1 million.

Gundersen Lutheran Administrative Services, Inc.

Gundersen Lutheran Administrative Services, Inc., a nonprofit, Wisconsin corporation, provides administrative services to Gundersen Clinic, Gundersen Lutheran Medical Center, Gundersen Lutheran Health Plan, and Gundersen Lutheran Medical Foundation in La Crosse, Wisconsin. As of December 31, 2003, GLAS's unaudited financial statements reported assets of $249 million, liabilities of $251 million, and net assets of $(1.8) million.

Affiliated Agreements and Guarantees

Gundersen Lutheran Health Plan has entered into an affiliated agreement and guarantee. These agreements are described below:

- Administrative Service Agreement among Gundersen Lutheran Administrative Services, Inc., and Gundersen Lutheran Health Plan, Inc., effective January 1, 2003. This agreement appoints the Health Plan as administrator to GLAS's self-funded employee health and welfare benefit plan.
- Management Services Agreement among Gundersen Lutheran Administrative Services, Inc., and Gundersen Lutheran Health Plan, Inc., effective January 1, 2003. This agreement provides that GLAS will provide such administrative services as may be necessary to ensure the operations of the Health Plan.
- Business Associate Agreement among Gundersen Lutheran Health Plan, Inc., and Gundersen Lutheran Administrative Services, Inc., as agent for Gundersen Clinic, Ltd., and Gundersen Lutheran Medical Center, Inc. This agreement provides that certain health information and records kept and maintained by the Health Plan are confidential under ss. 51.30 and 146.82, Wis. Stat., Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Standards for Privacy of Individually Identifiable Health Information.
- Parental Guaranty whereas Gundersen Clinic, Ltd., and Gundersen Lutheran Medical Center, Inc., will contribute the funds necessary to Gundersen Lutheran Health Plan, Inc., to protect members from suffering adverse consequences as a result of insolvency and financial requirements of the Health Plan to enter into a Medicare risk contract with the federal Health Care Financing Administration.

V. REINSURANCE AND CORPORATE INSURANCE

The HMO has reinsurance coverage under the contracts outlined below:

Reinsurer:

1. Reinsurer: Allianz Life Insurance Company

   Type: Specific Excess of Loss for Medicare HMO excluding capitated Members

   Effective date: January 1, 2004

   Retention: $300,000 per member

   Coverage: Eligible Hospital Expenses:

   Covered Acute Care
   For other than transplant period and transplant acquisition expenses:

1)	Paid at fixed fee	90%
2)	Not paid at a fixed fee	80

   For transplant period and transplant acquisition expenses:

1)	Paid at a LifeTrac Transplant Rate	90
2)	Paid at a Non-LifeTrac Transplant Rate	80
3)	Paid at other than the above	50

   Outpatient 90

   Professional Expenses 90

   $2,000,000 lifetime maximum per member

   For emergency out-of-area services, the reinsurer shall indemnify 80% of the loss between $25,000 and $220,000 for each member for each contract year

   Premium: $0.43 per member per month

   Termination: Twelve months from the effective date

2. Reinsurer: Allianz Life Insurance Company

   Type: Specific Excess of Loss for Commercial HMO excluding capitated Members

   Effective date: January 1, 2004

   Retention: $300,000 per member

   Coverage: Eligible Hospital Expenses:

   Covered Acute Care
   For other than transplant period and transplant acquisition expenses:

1)	Paid at fixed fee	90%
2)	Not paid at a fixed fee	80

For transplant period and transplant acquisition expenses:

1)	Paid at a LifeTrac Transplant Rate	90
2)	Paid at a Non-LifeTrac Transplant Rate	80
3)	Paid at other than the above	50

Outpatient 90

Professional Expenses 90

$2,000,000 lifetime maximum per member

For emergency out-of-area services, the reinsurer shall indemnify 80% of the loss between $25,000 and $220,000 for each member for each contract year

Premium: $0.34 per member per month

Termination: Twelve months from the effective date

3. Reinsurer: Allianz Life Insurance Company

Type: Specific Excess of Loss for Commercial POS excluding capitated Members

Effective date: January 1, 2004

Retention: $300,000 per member

Coverage: Eligible Hospital Expenses:

Covered Acute Care
For other than transplant period and transplant acquisition expenses:

1)	Paid at fixed fee	90%
2)	Not paid at a fixed fee	80

For transplant period and transplant acquisition expense:

1)	Paid at a LifeTrac Transplant Rate	90
2)	Paid at a Fixed Transplant Rate	80
4)	Paid at other than the above	50

Outpatient 90

Professional Expenses 90

$2,000,000 lifetime maximum per member

For emergency out-of-area services, the reinsurer shall indemnify 80% of the loss between $25,000 and $220,000 for each member for each contract year

Premium: $0.36 per member per month

Termination: Twelve months from the effective date

The reinsurance policies have endorsements containing the following insolvency provisions which are capped at $1,000,000:

1. Allianz Life Insurance Company will continue plan benefits for members who are confined in an acute-care hospital on the date of insolvency until the earlier of 365 days or the date of their discharge.

2. Allianz Life Insurance Company will make available to all members, other than Medicaid or Title XVIII Medicare enrollees, for a period of thirty days, without evidence of insurability, replacement coverage of the same benefit schedule and rates as then being offered by Allianz Life Insurance Company to other prospective insureds within the state.

In addition, the company is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	**Policy Limits**
Directors' and officers' liability	$ 20,000,000
Professional liability	1,000,000
Z-Med Property Policy	358,283,282
Managed Care Liability	6,000,000
Crime	
Employee Dishonesty	5,000,000
Forgery or Alteration	5,000,000
On Premises	5,000,000
In Transit	5,000,000
Computer Fraud & FTF	5,000,000

The above coverages were obtained through various insurers which are licensed in Wisconsin, or on the commissioner’s current list of approved surplus lines insurers.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported in the December 31, 2003, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the company for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Capital and Surplus per Examination."

Gundersen Lutheran Health Plan, Inc.
Assets
As of December 31, 2003

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$ 5,034,546	$	$ 5,034,546
Cash, cash equivalents and short-term investments	6,933,900		6,933,900
Investment income due and accrued	15,125		15,125
Uncollected premiums and agents' balances in the course of collection	5,623,481	7,095	5,616,386
Amounts recoverable from reinsurers	931,095		931,095
Other assets nonadmitted	125,042	125,042	
Aggregate write-ins for other than invested assets	41,518		41,518
Total Assets	$18,704,707	$132,137	$18,572,570

Gundersen Lutheran Health Plan, Inc.
Liabilities and Capital and Surplus
As of December 31, 2003

Claims unpaid		$ (1,505,518)
Unpaid claims adjustment expenses		112,000
Premiums received in advance		9,875,449
General expenses due or accrued		359,451
Amounts due to parent, subsidiaries and affiliates		781,590
Liability for amounts held under uninsured accident and health plans		325,000
Aggregate write-ins for other liabilities [including $(1) current]		161,837
Total liabilities		10,109,809
Gross paid in and contributed surplus	$1,125,000	
Surplus notes	2,044,803	
Unassigned funds (surplus)	5,292,958	
Total capital and surplus		8,462,791
Total Liabilities, Capital and Surplus		$18,572,570

Gundersen Lutheran Health Plan, Inc.
Statement of Revenue and Expenses
For the Year 2003

Net premium income		$125,369,101
Medical and Hospital:		
Hospital/medical benefits	$ 87,255,983	
Outside referrals	5,779,217	
Emergency room and out-of-area	4,016,986	
Prescription drugs	10,930,897	
Aggregate write-ins for other medical and hospital	6,198,491	
Subtotal	114,181,544	
Less		
Net reinsurance recoveries	5,709	
Total medical and hospital	114,175,835	
Claims adjustment expenses	3,868,988	
General administrative expenses	5,281,176	
Total underwriting deductions		123,325,999
Net underwriting gain or (loss)		2,043,102
Net investment income earned		10,042
Net Income (Loss)		$ 2,053,144

Gundersen Lutheran Health Plan, Inc.
Capital and Surplus Account
As of December 31, 2003

Capital and surplus prior reporting year		$6,513,825
Net income or (loss)	$2,053,144	
Change in nonadmitted assets	(104,208)	
Net change in capital and surplus		1,948,936
Capital and Surplus End of Reporting Year		$8,462,761

Gundersen Lutheran Health Plan, Inc.
Statement of Cash Flows
As of December 31, 2003

Premiums collected net of reinsurance		$125,691,789
Net investment income		20,728
Total		125,712,517
Less:		
Benefit and loss related payments	$115,887,866	
Commissions, expenses paid and aggregate write-ins for deductions	9,224,438	
Total		125,112,304
Net cash from operations		600,213
Cost of Investments Acquired - Long-Term Only:		
Bonds	5,044,688	
Other invested assets	104,208	
Net cash from investments		(5,148,896)
Cash Provided/Applied:		
Other cash provided (applied)		4,756
Net change in cash and short-term investments		(4,543,927)
Beginning of year (cash and short-term investments)		11,477,827
End of Year (Cash and Short-term Investments)		$ 6,933,900

Growth of Gundersen Lutheran Health Plan, Inc.

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2003	$18,572,570	$10,109,809	$8,462,761	$125,369,101	$114,175,835	$2,053,144
2002	18,085,227	11,571,402	6,513,825	108,447,424	97,750,284	1,607,563
2001	14,399,422	9,465,231	4,934,191	84,385,184	74,002,354	2,140,966
2000	11,098,355	8,305,130	2,793,225	56,182,374	49,211,120	776,198

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2003	1.6%	91.1%	7.3%	2.6%
2002	1.5	90.1	8.4	1.0
2001	0.6	87.8	11.6	11.5
2000	(1.8)	87.6	14.2	31.2

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2003	32,878	505.85	4.31
2002	32,050	394.61	3.94
2001	31,750	313.77	3.79
2000	28,470	270.22	3.53

Per Member Per Month Information

	2003	2002	Percentage Change
Premiums:			
Commercial	$265.83	$234.33	13.4%
Medicare	520.19	495.44	5.0
Expenses:			
Hospital/medical benefits	228.05	188.09	21.2
Outside referrals	15.10	14.60	3.4
Emergency room and out-of-area	10.50	10.32	1.7
Other medical and hospital	16.20	14.70	10.2
Prescription drugs	28.56	27.87	2.5
Less: Net reinsurance recoveries	.01	0.00	N/A
Total medical and hospital	298.40	255.58	16.8
Claims adjustment expenses	10.11	10.02	0.9
General administrative expenses	13.80	13.71	0.7
Total Underwriting Deductions	$322.32	$279.31	15.4

The HMO's growth from its Medicare+Choice Product began leveling off in 2002 and 2003 with enrollment increasing 11.5%, 1.0%, and 2.6% in 2001, 2002, and 2003, respectively. Although enrollment has increased during the period, Gundersen has suffered a decline in enrollment from commercial business. The HMO's net worth increased 203% over the examination period; which is primarily due to positive underwriting results in all three years and increased membership in its Medicare+Choice Product. Medical expenses during the period under examination increased 132% due to increased medical costs industry wide and increased enrollment in Medicare members which is a higher utilizing group.

Reconciliation of Capital and Surplus per Examination

The following schedule is a reconciliation of capital and surplus between that reported by the company and as determined by this examination:

Capital and surplus December 31, 2003, per annual statement			$8,462,761
Examination Adjustments:	**Increase**	**Decrease**	
Amounts Recoverable from reinsurers	$143,414	$	
Claims Unpaid		(143,414)	
Net increase or (decrease)	$143,414	$(143,414)	0
Capital and surplus December 31, 2003, per examination			$8,462,761

Examination Reclassifications

	Debit	**Credit**
Premiums Received in Advance	$5,403,194	$
Uncollected premiums and agents' balances in course of collection		5,403,194
TPA Administration Fee	161,837	
Amounts receivable relating to uninsured plans		161,837
Receivables from parent, subsidiaries and affiliates	1,362,104	
Claims Unpaid		1,362,104
Total Reclassifications	$6,927,135	$6,927,135

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were eleven specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the company are as follows:

1. Biographical Sketches—It is again recommended that the HMO file biographical sketches within 15 days of the election or appointment of any new director, trustee, or officer as required by s. Ins 6.52, Wis. Adm. Code.

   Action—Compliance

2. Holding Company—It is recommended that the HMO comply with the due date for the holding company filing pursuant to s. Ins 40.03 (2), Wis. Adm. Code.

   Action—Compliance

3. Business Plan—It is recommended that the HMO file a change in business plan within thirty days upon adoption of this report pursuant to s. Ins 9.06, Wis. Adm. Code.

   Action—Compliance

4. Business Plan—It is recommended that the HMO file substantial changes in its business plan in the future as required by s. Ins 9.06, Wis. Adm. Code.

   Action—Compliance

5. Financial Reporting—It is again recommended that the HMO complete the Notes to the Financial Statements in accordance with the Annual Statement Instructions for Health Maintenance Organizations.

   Action—Compliance

6. Affiliated Agreements—It is recommended that the HMO draft an administrative services agreement with Gundersen Lutheran Medical Center for the services being provided and submit the agreement to the commissioner as required by s. Ins 40.04, Wis. Adm. Code.

   Action—Partial Compliance (see the section of the report captioned “Summary of Current Examination Results”)

7. Affiliated Agreements—It is recommended that the HMO include an indemnification clause in affiliated agreements to address security incidents.

   Action—Compliance

8. Invested Assets—It is recommended that the HMO develop a plan that outlines how the HMO will comply with compulsory surplus requirements for future filings and file the plan with this office within sixty days of adoption of this report.

   Action—Compliance

9. Administrative Agreements—It is recommended that the HMO execute an administrative agreement with the self-funded group for the services provided.

   Action—Compliance

10. Accounts and Records—It is recommended that the HMO provide to this office further documentation on its TPA claim deposit as well as draft an agreement with the City of La Crosse regarding the purpose of such deposit.

    Action—Compliance

11. Disaster Recovery Plan—It is recommended that the HMO complete a disaster recovery plan by December 31, 2002, to be filed with this office.

    Action—Compliance

Summary of Current Examination Results

Executive Compensation

The examination review of the Report on Executive Compensation (Form OCI 22-060) for 2003 noted that the form is not being completed correctly. For example, the HMO is required to list the chief executive officer, the four most highly paid officers or employees (other than the chief executive officer), and any officer or employee whose total annual compensation is in excess of $80,000. It was noted that the HMO stated $0 compensation for its Executive Director and listed no other officers or employees. In addition, the form instructs those insurers that are part of a holding company system that they may file the form on a gross or allocation basis and to disclose which method in the footnotes. The HMO does not have employees, but is allocated a portion of salaries for those individuals that work on the HMO from Gundersen Lutheran Administrative Services, Inc. Therefore, the form should have been completed on the allocation basis. It is recommended that the HMO complete the Report on Executive Compensation (Form OCI 22-060) in accordance with its instructions.

Affiliated Agreements

During the prior examination it was noted that the HMO had an administrative services agreement with Gundersen Clinic, Ltd. It was also noted that the HMO was paying Gundersen Lutheran Medical Center for services such as IT employees, telephone, and office services. At that time the HMO did not have an agreement with the medical center and it was recommended the HMO enter into an agreement with the medical center and file the agreement with the commissioner as required by s. Ins 40.04, Wis. Adm. Code.

During review of the current management services agreement it was noted the HMO entered into a new management services agreement with Gundersen Lutheran Administrative Services (GLAS) effective January 1, 2003. However, this agreement was not filed with the commissioner until July 17, 2003. In accordance with s. Ins 40.04, Wis. Adm. Code, an insurer must submit agreements of this type to the ". . . commissioner 30 days before the domestic insurer enters into the transaction . . .." It is recommended that the HMO file agreements for non-disapproval in the timeframe permitted by s. Ins 40.04, Wis. Adm. Code.

Financial Reporting

The review of the annual statement noted the following errors:

- Schedule D Part 1 – Column 5 (How Paid) stated "S/A" meaning semi-annually. This column should actually report what months interest is paid in.
- Schedule D Part 1 – Column 4 (Interest) stated the yield rate given to dollar price versus the actual coupon interest rate.
- Schedule D Part 1 – Column 12 (Fair Value) reported the amortized value versus the actual fair value (market value).
- Schedule Y Part 2 – It was stated that one of the HMO's affiliates is "Lutheran Hospital – La Crosse." This is actually Gundersen Lutheran Medical Center, Inc., the affiliates actual name should be disclosed in this schedule.

It is recommended that the company properly fill out the annual statement in accordance with the NAIC Annual Statement Instructions – Health.

Investments

The examination noted that the HMO does not have a formal investment policy. The investment policy should set forth specific guidelines as to the quality, maturity, and the diversification of the investments of the HMO. It is recommended that the HMO implement a formal investment policy that outlines the quality, maturity, and diversification of the HMO's investments.

The examination review of the board of director minutes disclosed the board does not review and subsequently approve the HMO's investments. The accounting department does have the authority to make the HMO's investment decisions. However, these investment decisions are not formally approved by the board of directors or a committee of the board of directors. It is recommended that the HMO establish procedures to have investment transactions formally reviewed and approved by the board of directors on at least a quarterly basis.

The examination noted the HMO holds its investments in an account with a brokerage service. Examiners requested a copy of the HMO's custodial agreement with the brokerage service; however, the HMO was unable to produce a signed agreement with the proper indemnification language as stated in the NAIC Financial Conditions Examiners Handbook Part 1, Section J. In addition, insurers are to hold its investments with a custodian deemed to be a national bank, state bank, or trust company that is adequately capitalized, regulated, and qualified

to accept securities in accordance with s. 610.23, Wis. Stat. It is recommended the HMO enter into a custodial agreement in accordance with s. 610.23, Wis. Stat., with the proper indemnification language in accordance with the provisions specified in the NAIC Financial Conditions Examiners Handbook, Part 1, Section J.

Premium

The examination's review of the HMO's "Uncollected premiums and agents' balances in the course of collection" and "Premiums received in advance" noted that the December 2003 balance for these two accounts was overstated by $5,403,194. This resulted in an examination reclassification of $5,403,194. This reclassification is reflected in the section of this report captioned "Reconciliation of Capital and Surplus per Examination." The HMO billed its January 2004 premium in December 2003 and recorded an accounts receivable for the premium when it was billed and recorded a liability for advanced premium at the same time. Pursuant to NAIC Accounting Practices and Procedures Manual SSAP No. 6, premiums receivables shall be recognized based on effective date of the insurance contract. Also, pursuant to NAIC Accounting Practices and Procedures Manual SSAP No. 54, advanced premiums is those premiums that have been received by the entity prior to the valuation date. It is recommended that the HMO correctly report "Uncollected premiums and agents' balances in the course of collection" and "Premiums received in advance" in accordance with NAIC Accounting Practices and Procedures Manual SSAP No. 6 and 54. It should be noted that the HMO has properly recorded "Uncollected premiums and agents balances in the course of collection" and "Premiums received in advance" in subsequent filings with the Office of the Commissioner of Insurance.

TPA Administrative Fees

The examination review of the HMO's self-funded businesses noted that there was an asset and liability reported in the amount of $161,837 for TPA fees billed in December 2003 for January 2004 services. This resulted in an examination reclassification of $161,837 between the asset and liability accounts. This reclassification is reflected in the section of this report captioned "Reconciliation of Capital and Surplus per Examination." Pursuant to NAIC Accounting Practices and Procedures Manual SSAP No. 47, a receivable shall only be recorded when

services have been rendered rather than when services have been billed. It is recommended that the HMO correctly report TPA administrative fees in accordance with NAIC Accounting Practices and Procedures Manual SSAP No. 47. It should be noted that the HMO has properly recorded TPA fees in subsequent filings with the Office of the Commissioner of Insurance.

Claims Unpaid

The examination noted that during review of "Unpaid claims" that this negative liability was actually a receivable from Gundersen Clinic, Ltd., and Gundersen Lutheran Medical Center, Inc., for claims paid by the HMO in excess of capitation amounts. Pursuant to the "HMO Annual Statement Packet," amounts due from affiliates can include current prepaid capitation not in excess of one month's capitation to an affiliated health care provider. This resulted in an examination reclassification of $1,362,104 between the "Claims unpaid" and "Amounts due from parent, subsidiaries and affiliates." This reclassification is reflected in the section of this report captioned "Reconciliation of Capital and Surplus per Examination." It is recommended that the HMO complete the annual statement in accordance to the instructions published by the Office of the Commissioner of Insurance. It should be noted that the HMO has properly recorded "Claims unpaid" in subsequent filings with the Office of the Commissioner of Insurance.

Reinsurance

The examination review of the HMO's reinsurance transactions determined that the HMO was reporting reinsurance recoverable on a cash basis. This resulted in an examination adjustment of $143,414 to both "Amounts recoverable from reinsurers" and "Claims unpaid." This adjustment is reflected in the section of this report captioned "Reconciliation of Capital and Surplus per Examination." Pursuant to NAIC Accounting Practices and Procedures Manual SSAP No. 61, a ceding entity (the HMO) must report amounts recoverable on claims. Therefore, the HMO must accrue, based on a reasonable estimate, the amount recoverable from its reinsurer for claims. It is recommended that the HMO properly report reinsurance transactions in accordance to NAIC Accounting Practices and Procedures Manual SSAP No. 61. It should be noted that the HMO has properly recorded reinsurance recoverable in subsequent filings with the Office of the Commissioner of Insurance.

Remittances and Items Unallocated

The examination review over the HMO's controls over claims noted that receipts received for coordination of benefits, subrogation, and reinsurance recoverables are not deposited until they are identified and determined to be appropriate. These receipts are kept in a locked file drawer near the claims processing staff. During further review, examiners noted that the accounting staff was unaware of the amount placed in this drawer. These receipts should be deposited on a timely basis and reported as "Remittances and items not allocated" on the statements filed with the Office of the Commissioner of Insurance in accordance with NAIC Annual Statement Instructions – Health. The amount of these receipts appears to be immaterial; therefore, no adjustment was made to surplus. It is recommended the HMO deposit receipts when received and establish a procedure to properly report receipts not identified in accordance with NAIC Annual Statement Instructions – Health.

EDP

The HMO uses Perot Systems as an Application Service Provider. The HMO provided a SAS 70, a review of controls, of Perot Systems as of April 2001. The SAS 70 is considered to be out of date and questionable as to the relevance on the control environment of the outside service center; therefore, the SAS 70 could not be relied on. It is recommended that the HMO require its Application Service Provider to provide an annual SAS 70 report on their control environment.

The examination review of the HMO's policies noted that there are no formal policies regarding the periodic review of security logs. These include firewall logs, computer room access logs, and security event logs for the network and applications identifying incorrect attempts to access applications and/or data. In order for a control to be effective, it needs to be periodically monitored. There should be a formal procedure for reviewing these logs. During the examination, it was identified that the HMO is developing an auditing standard. The auditing policy should be to assess whether the review process is taking place versus performing the review. It is recommended the HMO have formal periodic review processes developed and implemented for the review of security logs.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The company's calculation as of December 31, 2003, as modified for examination adjustments is as follows:

Assets	$ 18,572,570	
Less:		
Special deposit	1,100,000	
Liabilities	10,109,809	
Total		$7,362,761
HMO Net premium earned	125,118,378	
Compulsory factor	3%	
		3,753,551
POS Net premium earned	250,723	
Compulsory factor	10%	
Compulsory surplus		25,072
Compulsory Excess		$3,584,138

VIII. CONCLUSION

Gundersen Lutheran Health Plan, Inc., is a nonprofit, network model health maintenance organization serving La Crosse and surrounding counties. The HMO has an agreement with Gundersen Lutheran Administrative Services, Inc., through which it receives administrative services.

Gundersen's 2003 annual statement reported assets of $18,572,570, liabilities of $10,109,809 and surplus of $8,462,761. Operations for 2003 produced a net income of $2,053,144. Surplus over the examination period increased 203% as a result of improved underwriting results and increased enrollment from the HMO's Medicare+Choice product. Although Gundersen has increased its enrollment over the examination period; it has suffered a decrease in enrollment in its commercial business.

Gundersen complied with ten of the eleven prior recommendations, and partially complied with one recommendation. The partially complied recommendation was a result of the HMO filing its administrative service agreement with Gundersen Lutheran Administrative Services, Inc., after the timeframe stated in s. Ins 40.04, Wis. Adm. Code. Thirteen recommendations were made as a result of this examination regarding reporting errors in investments, premiums, claims, and reinsurance; and various compliance issues.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 28 - Executive Compensation—It is recommended that the HMO complete the Report on Executive Compensation (Form OCI 22-060) in accordance with its instructions.

2. Page 28 - Affiliated Agreements—It is recommended that the HMO file agreements for non-disapproval in the timeframe permitted by s. Ins 40.04, Wis. Adm. Code.

3. Page 29 - Financial Reporting—It is recommended that the company properly fill out the annual statement in accordance with the NAIC Annual Statement Instructions – Health.

4. Page 29 - Investments—It is recommended that the HMO implement a formal investment policy that outlines the quality, maturity, and diversification of the HMO's investments.

5. Page 29 - Investments—It is recommended that the HMO establish procedures to have investment transactions formally reviewed and approved by the board of directors on at least a quarterly basis.

6. Page 30 - Investments—It is recommended the HMO enter into a custodial agreement in accordance with s. 610.23, Wis. Stat., with the proper indemnification language in accordance with the provisions specified in the NAIC Financial Conditions Examiners Handbook, Part 1, Section J.

7. Page 30 - Premium—It is recommended that the HMO correctly report "Uncollected premiums and agents' balances in the course of collection" and "Premiums received in advance" in accordance with NAIC Accounting Practices and Procedures Manual SSAP No. 6 and 54.

8. Page 31 - TPA Administrative Fees—It is recommended that the HMO correctly report TPA administrative fees in accordance with NAIC Accounting Practices and Procedures Manual SSAP No. 47.

9. Page 31 - Claims Unpaid—It is recommended that the HMO complete the annual statement in accordance to the instructions published by the Office of the Commissioner of Insurance.

10. Page 31 - Reinsurance—It is recommended that the HMO properly report reinsurance transactions in accordance to NAIC Accounting Practices and Procedures Manual SSAP No. 61.

11. Page 32 - Remittances and Items Unallocated—It is recommended the HMO deposit receipts when received and establish a procedure to properly report receipts not identified in accordance with NAIC Annual Statement Instructions – Health.

12. Page 32 - EDP—It is recommended that the HMO require its Application Service Provider to provide an annual SAS 70 report on their control environment.

13. Page 32 - EDP—It is recommended the HMO have formal periodic review processes developed and implemented for the review of security logs.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the company is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

Name	Title
Rebecca Easland	Insurance Financial Examiner
Randy Milquet	Examiner - Advanced

Respectfully submitted,

Amy J. Wolff
Examiner-in-Charge